Montana Medicaid Claim Jumper

Important Information for All Providers on Submitting Claims

This article contains important new information for all providers submitting claims to the Montana Medicaid, Mental Health Services and Children's Health Insurance (dental and eyeglass only) plans.

The federal HIPAA law says that as of Oct. 16, 2003, all claims (except pharmacy—see p. 2) sent and received electronically must be in the standardized X12N 837 format. This format replaces about 400 formats currently in use, most of which are based on National Standard Formats (NSF) such as the UB-92 and the CMS 1500.

Across the U.S., however, many providers are not ready to send X12N formats and many health plans are not ready to receive X12N. The situation has raised fears of a nationwide "train wreck" in which providers are unable to submit claims and health plans are unable to pay providers.

On July 24, the federal Centers for Medicare and Medicaid Services (CMS) published important guidance on how it will enforce the HIPAA provisions on electronic transactions. Specifically, CMS addressed the question of providers that are not ready to send X12N formats and therefore want to continue sending current formats after Oct. 16.

The answer was that CMS will not impose penalties on these providers so long as they are making reasonable and diligent efforts to comply with the new standards. CMS also will not impose penalties on health plans (like DPHHS) that receive non-compliant transactions, under certain conditions.

CMS is clear that this relatively lenient approach will not last indefinitely, though it gives no time frame. **Providers that send electronic transactions must continue to work toward being able to conduct these transactions using X12N formats**.

The CMS guidance document provides more detail on these important points and every provider should read the document itself. It is available at *www.mtmedicaid.org.*

Providers serving clients of the Montana Department of Public Health and Human Services (DPHHS) need to know whether DPHHS will be able to accept X12N formats after Oct. 16 and whether DPHHS will continue to accept current formats for a limited time after Oct. 16. **The answer to both questions is yes**. Here are the seven different ways providers will be able to submit claims to DPHHS and its claims processing contractor, ACS State Healthcare.

HIPAA-Compliant Electronic Methods

1) X12N 837 formats sent directly to ACS from the provider.
2) X12N 837 formats sent to ACS through a clearinghouse chosen by the provider.
3) "WINASAP 2003" field software provided free by ACS. This software creates an X12N 837 format that can be submitted only to DPHHS. It will be available in September.

Current Electronic Methods

4) NSF (UB-92 and CMS-1500) formats sent directly to ACS from the provider.
5) NSF formats sent to ACS through a clearinghouse chosen by the provider.
6) "ACE$" field software provided free by ACS. This software creates a format that can be submitted only to DPHHS.

Paper Claims

7) Providers can continue to submit claims on paper. These claims typically take longer to process and are more subject to processing errors.

DPHHS will continue to accept current electronic methods for a limited time as a contingency to ensure the continued smooth flow of payments to providers. We will await further guidance from CMS on the time frame and we encourage all providers to move toward compliance as rapidly as possible.

For a limited time, providers can also choose to pick up their DPHHS electronic remittance advices either in the HIPAA-compliant X12N 835 format or in the current non-compliant format. Remittance advices will be produced in both formats.

Providers who are ready to do claims and remittance advice transactions in X12N formats must first enroll with the ACS clearinghouse. ACS has arranged for Montana providers to test their ability to send X12N formats to ACS free of charge. For further details, go to the "HIPAA Update" pages at *www.mtmedicaid.org* or call the ACS clearinghouse at 800-989-6719.

Claims Submission for Pharmacies

Almost all pharmacies serving DPHHS clients currently submit claims using point-of-sale technology based on the NCPDP 3.2 pharmacy claim format. Under HIPAA, the only approved format is NCPDP 5.1.

DPHHS and its claims processing contractor, ACS State Healthcare, will start accepting NCPDP 5.1 on Wednesday, October 1. ACS will continue to **also** accept NCPDP 3.2 until October 16, 2003.

Since the pharmacy industry is generally well prepared for the transition to NCPDP 5.1, the Department has determined that it will not be necessary to invoke a contingency plan of continuing to accept the old format. As of October 16, ACS will no longer accept NCPDP 3.2.

Like other providers serving DPHHS clients, pharmacies will have the option of picking up their electronic remittance advices either in the HIPAA-compliant X12N 835 format or, for a limited time, in the current non-compliant format. Pharmacies need not notify ACS or DPHHS which format they will pick up from electronic bulletin boards, though pharmacies that want to have the option of picking up X12N 835 remittance advices will need to enroll with the ACS clearinghouse.

For further details, see the HIPAA fact sheet available at *www.mtmedicaid.org*.

Medicaid Hard Cards are here!

The *Montana Access to Health* Medicaid Hard Cards were mailed to all clients in mid-August. Each eligible client will receive a card, rather than one card per family. The *Montana Access to Health* card will only be mailed out once, unless the client loses their card or it is stolen.

The *Montana Access to Health* card includes the client's name, their date of birth, and a unique card control number. It does not contain PASSPORT provider information, or eligibility dates since the client will keep this card throughout any changes in eligibility status.

Since the eligibility information will not appear on the *Montana Access to Health* card, it will be necessary for providers to verify eligibility before providing services. There are a variety of eligibility verification resources for providers to use.

From a query into any of the eligibility verification services listed below, the provider will learn if the client is eligible for Medicaid on the requested date of service; who the client's PASSPORT provider is (if enrolled in Managed Care); if the client has other insurance coverage (TPL); cost share; and other information regarding eligibility.

AVRS (800) 714-0060 – this eligibility verification resource issues an instant phone message about the client's eligibility. Available 24 hours a day, 7 days a week.

FAXBACK (800) 714-0075 – this eligibility verification resource sends a FAX to the provider's FAX machine with the client's eligibility listed. Available 24 hours a day, 7 days a week.

MEPS *vhsp.dphhs.state.mt.us* – this eligibility verification resource requires that the provider register before use; it issues eligibility verification that can be printed for client's file. Available 24 hours a day, 7 days a week.

MEDIFAX EDI *www.medifax.com;* (800) 444-4336 – MEDIFAX has a variety of options for eligibility verification, ranging from a point-of-sale terminal to Internet sites listing eligibility. Call Sheri Smith at x2072 for additional information on these services.

Eligibility can also be verified by calling Provider Relations at (800) 624-3958 in state or at (406) 442-1837 out-of-state or in Helena.

Attention: Psychologists, LCPCs, and Social Workers

Claims with CPT codes commonly used by psychologists, counselors, and social workers are manually priced which generally requires more time to process. Providers may see EOB code 900 on their statements indicating that the claim is in suspense (in process) while the claim is priced manually. This applies to services with dates of service from January 15, 2003 through June 30, 2004. However, claims will be manually priced through June 30, 2004. Providers submitting claims electronically should try to transmit claims Thursday, Friday, or Monday before 3:00 pm. to avoid undue delay in payment.

Unbundling of Inpatient and Outpatient Claims at Critical Access Hospitals

Montana Medicaid policy requires all hospitals to bundle an outpatient claim with the inpatient claim if an inpatient stay is necessary. Medicare now requires critical access hospitals to unbundle outpatient and inpatient claims and bill separately (per Medicare Hospital Manual Transmittal 788). Because of this difference in policies, numerous claims submitted to Medicaid have been denied.

Montana Medicaid sought the assistance of ACS (our fiscal intermediary) in an effort to permit CAHs to unbundle these claims. However, after several Joint Application Design (JAD) sessions with ACS it was determined that the remediation of the MMIS to permit unbundling was problematic. Therefore, this project was abandoned.

Montana Medicaid will continue to require all hospitals to bundle an outpatient claim with the inpatient claim if an inpatient stay is necessary.

Notice about Proposed Administrative Rule Change

On February 14, 2003, the Department filed a proposed amendment to Administrative Rule 37.86.1101. The proposed amendment is hereby cancelled. The proposed amendment would have changed the reimbursement to pharmacy providers by increasing the percentage off the Average Wholesale Price (AWP) for generic multiple source drugs without Federal Upper Limits. Pharmacy Providers will continue to be reimbursed for covered drugs at the lesser of:

- The providers usual and customary charge
- The estimated acquisition cost (AWP less 15 percent) plus a dispensing fee
- The maximum allowable cost plus a dispensing fee

Any questions regarding this cancellation can be directed to Dan Peterson at (406) 444 2738.

PASSPORT Update

As of October 1, 2003, Prairie County will participate in the PASSPORT To Health Managed Care Program. Please refer to the notice dated October 1, 2003 on *www.mtmedicaid.org* or see the "Recent Publications" section for more information.

Providers should use one of the Medicaid eligibility methods to obtain the primary care provider's name and telephone number to request PASSPORT approval.

Attention: Therapeutic Group Homes and Family Care services

The modifiers for the following services have been changed and will become effective with dates of service on or after September 1, 2003.

Campus-based Youth Group Therapeutic Home Leave	S5145 TF
Intensive Youth Group Home Therapeutic Home Leave	S5145 TG
Permanency Therapeutic Family Care	S5145 HD

These modifiers have been updated in the on-line fee schedules.

HIPAA-compliant Diagnosis Codes

This is a reminder that invalid diagnosis codes are not HIPAA-compliant and will no longer be accepted by the DPHHS claims processing system. Please verify that you are using the most updated version of your ICD-9 code book (2003) and that you are using the diagnosis code with the highest degree of specificity. Claims with invalid diagnosis codes will be denied.

Recent Publications

The following are brief summaries of publications regarding recent program policy changes. For details and further instructions, download the complete notice from the Provider Information website (http://www.mtmedicaid.org). Select Notices and Replacement Pages, and then select your provider type for a list of current notices. If you cannot access this information, contact provider relations.

New Notices

10/01/03 All Medicaid Providers
PASSPORT to Health in Prairie County

08/05/03 Physicians, Mid-Level Practioners, Hospitals, IDTFs, Psychiatrists, Podiatrists, and Lab & X-ray Providers
2002-2003 ATP Tests and Fee Schedules

08/05/03 Physician and Hospital Providers
Medicaid Observation Bed Criteria

07/31/03 Hospital, Physician, Mid-Level Practitioner, RHC, FQHC and IHS Providers
CMS-1500 in the emergency room

07/01/03 Pharmacy
MHSP Pharmacy Changes

07/01/03 All Medicaid Providers
Montana Medicaid Notice

New Fee Schedules

The following fee schedules have been updated as of July.

ATP Lab Panel Fees
Dentist
Hospital Outpatient
Laboratory/X-ray
Mid-level Practitioner
Occupational Therapy
Physician
Speech Therapy

Montana Medicaid
ACS
P.O. Box 8000
Helena, MT 59604

PRSRT STD
U.S. Postage
PAID
Helena, MT
Permit No. 154

Key Contacts

Provider Information Website:

http://www.mtmedicaid.org

ACS EDI Gateway Website:

http://www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm

ACS EDI Help Desk (800) 987-6719

Provider Relations (800) 624-3958 Montana
(406) 442-1837 Helena and out-of-state
(406) 442-4402 fax

TPL (800) 624-3958 Montana
(406) 443-1365 Helena and out-of-state

Direct Deposit Arrangements (406) 444-5283

Verify Client Eligibility:
FAXBACK (800) 714-0075
Automated Voice Response (800) 714-0060

Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944

PASSPORT (800) 480-6823

Prior Authorization:
DMEOPS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

Provider Relations
P.O. Box 4936
Helena, MT 59604

Claims Processing
P.O. Box 8000
Helena, MT 59604

Third Party Liability (TPL)
P.O. Box 5838
Helena, MT 59604